

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

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HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 01-05 2. STATE: New York
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT **xxx**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: <div style="text-align: center;">42 CFR 447.300</div>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2000-2001</u> \$ <u>255,000</u> b. FFY <u>2001-2002</u> \$ <u>339,000</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B Page 16	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable): None</i>

10. SUBJECT OF AMENDMENT: **Non-Institutional Services-Hyperbaric Oxygen Therapy Services**

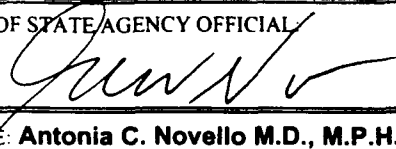
11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED **xxx**

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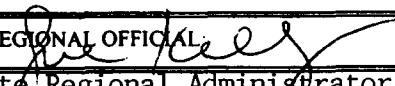
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: New York State Department of Health, Corning Tower, Empire State Plaza, Albany NY 12237
13. TYPED NAME: Antonia C. Novello M.D., M.P.H., Dr. P.H.	
14. TITLE: Commissioner	
15. DATE SUBMITTED: March 29, 2001	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 30 2001	18. DATE APPROVED: APR 26 2001
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2001	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Sue Kelly	22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS:

According to the Paperwork reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The OMB control number for this information collection of 0938-0193. The time required to complete this information collection is 10 hours (or minutes) per response, including the time to review instructions, search existing data resources, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

FORM HCFA-179 (07-92) *Instructions on Back*

Hyperbaric Oxygen Therapy (HBOT)

The Department of Health will conduct a pilot reimbursement program for a period of three years to study and determine the efficacy of funding certain outpatient HBOT services provided by select hospitals in New York State.

- (a) Hospitals will be selected based upon their experience in providing outpatient HBOT services and pending appeals to establish specialty outpatient HBOT rates of reimbursement, which were submitted to the Department no later than January 25, 2000. In order to participate in the program, such hospitals will be required to submit quarterly reports to the Department that include specific measurable outcomes in order to determine the effectiveness of the program.**
- (b) Outpatient HBOT services covered by Medicaid in this pilot program include only those listed in Section 35-10A of the Medicare Coverage Issues Manual published by the Health Care Financing Administration.**
- (c) The payment rate for outpatient HBOT services provided in accordance with section 35-10A of the Medicare Coverage Issues Manual shall be the current Medicare APC rate paid through the hospital outpatient prospective payment system.**

TN ~~01-05~~

Supersedes TN **New**

Approval Date

APR 26 2001

Effective Date

JAN 01 2001